# CURB
# Meeting Minutes
# October 1, 2014



**PRESENT:**
**Board:** Michel Benoit, MD, Delores Burroughs-Biron, MD, David Butsch, MD, Ann Goering, MD, John Matthew, MD, Paul Penar, MD

**DVHA Staff:** Daljit Clark, Jennifer Herwood, Susan Mason, Thomas Simpatico, MD (moderator), Scott Strenio, MD, Kara Suter

**Guests:** Sharon Mallory, Madeleine Mongan

**Absent**: Patricia Berry, MPH, William Minsinger, MD, Norman Ward, MD, Richard Wasserman, MD

## HANDOUTS

- Agenda
- Draft minutes from 7/16/2014
- Economic Modeling Samples
- Briefing to CURB on Episodes of Care (EOC) Presentation

## CONVENE: Dr. Thomas Simpatico convened the meeting at 6:35 pm.

## 1.0 Introductions

## 2.0 Review and Approval of Minutes

The minutes were reviewed and approved as written.

## 3.0 Updates:

### Meeting Schedule 2015
Dr. Simpatico asked the group if they were in favor of continuing the schedule of meeting every other month. The group was in favor of this.

### Feedback
Dr. Simpatico told the group that we will circle back on issues previously discussed, for example Partial Hospitalization Program (PHP) and Rapid Evaluation and Management of TIA and Minor Stroke (REMOT). The REMOT hit funding bumps, there will be changes to the funding, and things may start moving ahead.

### Hub and Spoke
Dr. Simpatico gave an update on the Hub and Spoke. The governor reminds us about the focus on opioid dependency. There was a presentation to the National Governors

Association Policy Academy. There is a dissonance between what Joint Commission Accreditation, Health Care (JCAHO) dictates and Center for Medicare and Medicaid Services (CMS) pain control promotes versus our efforts to reduce opioid dependency. There was a lot of commonality. There is pressure on the physicians to check the Vermont Prescription Drug Monitoring System (VPMS). There is not enough shared responsibility, if there is a problem. There should be more of push technology. There should be a focus on shared responsibly. Red flag information can be "pushed" to the physicians. We are actively involved and looking at what we can do right now with VPMS. What can be done outside of the 1-2 years electoral cycle?

The New England Comparative Effectiveness Public Advisory Council (CePAC) addresses specific policy makers, uses economic predictive modeling focused on the next steps for payers and policy makers. For every $ spent on opioid replacement therapy, you save $1.80. It is budget neutral just looking at health care costs. Looking at social services, the savings is 2:1. What if we implement what we need to do based on predictive modeling? We can undercut the illicit drug trade; it may be a game of whack-a- mole and something else may arise, but this is what the governor wants to do.

**Discussion –**
Recommend that the Health Department push new information forward.
Decrease the adversarial approach, increase shared responsibility.

Recommendations include:
Change regulations that isolate methadone treatment and include office based treatment.
There would need to be an infrastructure including testing and social services.

Pain vs methadone maintenance at the office is a concern, would want pain specialist input.
Relax limits for patients treated with buprenorphine.
Jail diversion programs.
Expand treatment to incarcerated folks and have integration into the community.
Coordinated care (hub and spoke).
Add counseling to treatment plans.
Institute an efficient PA process.
Working on achieving adequate capacity, no waiting lists, for opioid replacement.
Important to warn people that it will affect their hormones and cause osteoporosis, it may decrease interest in obtaining opioids.

Prevention of Opioids Abuse:
Public information campaigns, enhances training for prescribers, access to expertise, are all being discussed and planned.
Working with other payers as well, possibly a "tool kit" for new providers to put out jointly.

## 4.0 Old Business:

**Vermont Medical Society Letter**
We want to have better strategies for good communication vs information privacy.

Vermont Medical Society (VMS) likes the idea of the push notices for evidence based practice. Pick some pilot areas such as an outcome indicator of death rate to move VT closer to HIPAA regulations and nothing beyond that.
VMS is are happy to help and to work with us, but they have complications of 42CFR. They love the idea of push notes to physicians.

**Discussions**
VT Medicaid used to send info on what was being prescribed, who prescribed it and if patients were filling their prescriptions. The doctors found this valuable. It seems to have ended, could it be reestablished?

**Action Item:**
Daljit Clark will ask the Pharmacy Director. The push could go to an email or a user portal. We will report back to board at the next meeting.

## 5.0 New Business:

**Episodes of Care –**
Kara Suter, DVHA Director of Payment Reform and the State Innovation Model (SIM) has a three year grant from CMS to create a payment model based on analytics.
Vermont is one of six testing States. It is based on an episode of care from trigger to post event. It is based on an episode of care grouper.
We already have episodic bundling happening in certain contexts such as a hospital based surgery. But now we are looking for bundling across different venues. Arkansas focuses on bundled payments, looking at all pertinent providers across all pertinent settings. Arkansas doesn't have a shared saving Accountable Care Organization (ACO) program if in the acceptable range; you get more from these who were not in the acceptable range.
The models could be just inpatient or 90 days after as well.

SIM analytics will be presented at a webinar. SIM is working collaboratively with stakeholders to determine how the analytics would be helpful for educational purposes and performance tracking, not really focusing on payment model use at this time.
Providers are not interested on focusing on episodes.
Sample size is an issue in VT due to its small population.

We don't have an incentive program currently.
Critical access hospitals are paid the same by Medicaid not Medicare, but the data is affected by pricing valuation.
Arkansas posts all of their definitions and so while valuations are there, at least it is transparent.
All data is based on claims, not patient records. Kara's data is based on a four year compilation, due to the small sample size in VT.
Medicaid pays more due to the psychosocial differences for most but not all disease processes particularly the chronic ones.

An example: colonoscopy – one group used the data to create efficiency scores for the GI doctors in their network. Some were totally outside the norm, they were scoping 100% instead of 30% and the literature suggested 30% of the time.
There is also an approach that tries to remove the variables that may affect validity it takes just routine episodes, low level severity. This data looks at practice patterns and uncovers issues with it.
They choose clear cut cases with no comorbidities to qualify for the case. This really shows the practice patterns. It is a more practical method. We are trying to find practical information, from a primary care base, to push forward information about primary care and about specialists.
Practical examples include c section rates. The group appears interested in obtaining this practical information comparing practice patterns.

Kara Suter asked the board for recommendations.

**Discussion:**
How does neurosurgery fit into this model? Who brings value to this picture?
The tool can be used for care delivery
Transformation and for payment control

Do any of the programs take into account the type of patient you are dealing with and their willingness to participate? Acuity = yes and personality= no, this does not look at the personality of the patient.

Coding variation can affect the data

## 6.0 Technology Requests:

**Low Dose Chest CT Scan for Lung Cancer Screening**

Dr. Strenio presented his recommendation to cover low dose chest CT scan for lung cancer screening.

The presentation is from Medsolutions, VT Medicaid's Radiology vendor.
There are15-20% fewer deaths from lung cancer in the low dose CT (LDCT) group. The net benefit is moderate or substantial.
The recommendation if for an annual screening for 55-80 year olds with a 30 pack year history who smoke or smoked within the past 15 years.
American Academy Family Medicine felt the statistics were not strong enough to recommend it.

FAHC has a pilot program. It is an integrated screening program. A dedicated database will be developed to:

Track individuals eligible for screening
Mark all interactions with patients and their primary care providers
Update all tobacco data

PMPM impact is about $.08.
There is some concern about more tests due to false positive.

**Discussion –**
These stats were brought to FAHC it wasn't clear that the procedures saved lives for the amount of money used.
There is concern about the amount of radiation.

Will people feel safer continuing to smoke knowing that they are being tested annually?
People need to hear from their PCPs to quit smoking.
If the screening is positive does that engender more testing?

The prior authorization (PA) process is too much for the PCPs; if criteria are met then they should be eligible for screening.

**Action Item:**
The group agreed to endorse it. They recommend that we cover the low dose CT scan and follow it.

**Adjournment – CURB meeting adjourned at 8:40 PM**

**Next Meeting**
**November 19, 2014**

**CURB**
**Meeting Minutes**
**October 1, 2014**



**Time: 6:30 PM – 8:30 PM**
**Location: Department of Vermont Health Access, Williston, VT**